Submission No. 79
(Overseas Trained Doctors)
Date: 17/02/2011

Thank you for the invitation for public comment on the Inquiry into the Registration Processes and Support for Overseas Trained Doctors.

My comments address primarily the third element of the terms of reference of the Inquiry: 'Suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies.' I work as a specialist obstetrician and gynaecologist so my comments refer primarily to overseas trained specialists seeking Australian specialist recognition and Fellowship of RANZCOG.

With respect to recruitment of overseas trained doctors to support health care services wherever they are in the country, key goals must be that all overseas trained doctors who provide care for people in Australian communities are well assessed, well oriented and well supported in their endeavours. The absolute primary concern must be that all who seek care in the Australian health care sector are cared for in a safe and sympathetic way, not that they are rushed into working in a setting with limited resoureces. Safety of care depends on many factors but extends well beyond having a health practitioner on hand who has passed an examination demonstrating a particular set of clinical knowledge at a point in time.

One measure which would help ensure that practitioners destined to work in rural areas are well oriented to the Australian health care system, well assessed with respect to clinical assessment, communication and procedural skills and well supported by professional peers is to insist that all doctors have the opportunity, and are expected, to undertake a period of closely supervised work in a major metropolitan centre.

This period of time may be long or short depending on initial assessment outcome. A short period of assessment for a well qualified and experienced clinician would not unduly delay deployment to a contracted post, and would provide valuable orientation to the health system, and opportunity to initiate important peer linkages to encourage appropriate referral patterns to higher level services when indicated.

The above suggestion would ensure that any medical practitioner entering the Australian health care sector can be oriented to the high standards of care expected by the community, enables the opportunity to make acquaintance of senior clinicians who may provide ongoing advice and clinical support, would provide contact with senior medical educators and knowledge of local education resources, and provides an independent avenue for clinical assessment in an environment where local training standards are well understood and devoid of the vested interest.

Such a period of orientation/assessment/ support development would not necessarily have to be a protracted endeavour where a clinician's professional and communication skills clearly meet the standards expected of an Australian trained practitioner. Where clinicians clearly do not meet

expectations of locally trained doctor then the potential for inappropriate and expensive practitioner recruitment to rural, outer metropolitan or academic positions can be avoided.

Where it becomes apparent that a clinician does not have skills equivalent to a locally trained practitioner but where a limited period of work experience in a well supported and supervised environment will likely enable a clinician to achieve the skills necessary to work in a safe and sympathetic manner, then major metropolitan centers should be charged to maintain a number of clinical positions which would enable such training to be completed within a flexible but defined maximum time frame. The workload and learning environment of major centres will enable more rapid upskilling than small workload centres with limited close supervision possibilities. Where such a practitioner's ongoing periodic assessments demonstrate major difficulties in achieving local clinical standards, then with clear prospective definition of the timeframe, expectations and process, the practitioner may be advised that he/she should seek general rather than specialist registration.

I have reached a strong conviction that a system such as that outlined above is necessary to improve the quality and efficiency of assessment and training for doctors recruited from overseas based a spectrum of experience. I have had an interest and involvement in the work of overseas trained doctors in Australia from a number of viewpoints over the last 15 years since commencing work in Bunbury in the southwest of WA, as a consultant obstetrician and gynaecologist in 1996. Earlier in my career I worked as an 'overseas trained doctor' firstly in rural Pakistan 1987–89 as a volunteer with Australian Volunteers Abroad , and in England 1994-1996 where I completed my specialist training in the National Health System.

My involvement with overseas trained doctors in recent years has been:

1. Working alongside a number of OTDs in Bunbury Western Australia where a cohort of doctors hailing mainly from South Africa & the United Kingdom have helped sustain both the GP and specialist workforce during a time when recruitment of locally trained doctors in the face of a rapidly increasing population was difficult.

2. Representing Provincial Fellows as a Councillor with the Royal Australian & New Zealand College of Obstetricians & Gynaecologists for 4 years. A significant proportion of RANZCOG Fellows working in rural areas are OTDs.

3. Four years as a member of the RANZCOG Overseas Trained Doctor and Area of Need assessment panel, two of those years as chairman of the OTD AON Committee during a time when RANZCOG made changes consistent with direction from the Australian Medical Council to streamline the pathway to Australian specialist recognition for overseas trained obstetrician gynaecologists.

4. Participation in assessment of overseas trained GP obstetricians through a process initiated by the WA Rural Workforce Support Agency- Rural Health West, to provide independent assessment of procedural skills of doctors recruited from overseas by rural health services.

5. Formal reviews of public Maternity Care Services in two regional areas of WA where many of the specialist and primary maternity care services are supported by overseas trained doctors.

6. In the past two years, supervisor for an overseas trained specialist in O&G who is working toward Fellowship of RANZCOG having been assessed as 'partially comparable' to an Australian trained specialist by the AMC assessment process. This doctor was the second OTD O&G registrar to work with the Bunbury O&G team in the last 4 years.

7. Recent recruitment to the team of clinicians at Bunbury Health Service who will be participating in the Work Based Assessment of doctors who have been given the opportunity of clinical skills assessment whilst employed at the hospital as medical officers instead of having to sit the oral AMC clinical examination to achieve registration as a medical practitioner with the Australian Health Practitioners Registration Authority.

The above accumulated experience leads me to make the following observations:

1. The Australian medical training system, generally speaking, trains doctors with both a good knowledge base relevent to Australian health care needs, and good clinical skills. The latter is achieved with the generous and understanding support of the Australian public by exposing medical students to clinical care from early in training. Not all overseas trained doctors have trained in similar systems, resulting in clinicians with theoretical knowledge without a strong clinical skill base. The value of clinical exposure in medical training cannot be underestimated in producing doctors sensitive to and capable of providing safe care. The recognition of 'Competent Authorities' for medical training systems deemed equivalent in nature to those of the Australian system is a positive move which recognizes that not all medical training is equivalent. I fully support this initiative which bypasses the need for doctors from these countries to pass the AMC examination or an equivalent assessment process to achieve AHPRA registration. Equally the need for some form of formal assessment of knowledge, communication and clinical skills for doctors not trained within a similar framework to that of Australian medical schools remains an important requirement for the assessment of overseas trained doctors.

2. Completion of Specialist (or GP) training overseas, even in Competent Authority nations does not guarantee a competent clinician. The motivations for OTDs seeking to work in Australia is many and varied. For most the reasons do not reflect on level of professional skill and behavior, but for some it does follow difficulties working in their home environment due to skill, personality or professional standards problems.
   Relying on other regional or national registration bodies to screen out such practitioners will not protect the public from all doctors with competency problems as some will manage to 'fly under the radar' without their practice drawing the attention of registration bodies. Disciplinary processes brought by local hospitals or health services are not necessarily disclosed to or uncovered by the AMC, OTD assessment panels and potential employers.

Australian assessment systems should strive to discern the latter small group of doctors before exposing the Australian public to suboptimally performing clinicians. This is a difficult but not, in my view, an insurmountable task. Having a robust and independent assessment process should help reassure communities and health care managers that where deficiencies are identified, that the decisions are based on high professional standards with the interests of community members as the prime objective.

3. Specialists assessed through current RANZCOG, and other specialist colleges may be assessed as not comparable, partially comparable and substantially comparable to an Australian trained specialist.
   The addition, by the AMC, of a requirement for all doctors rated in the substantially comparable group to undergo a limited period of oversight in specialist practice is wise. As indicated above, it is impossible to always 'get it right' when assessment is based on paperwork and an interview without observation of clinical practice.
   The potential flaw from an unbiased assessment perspective in the current system is that the doctor providing oversight is not usually a disinterested party. Practitioners recruited to rural health services often fill positions which medical administrators are under considerable public and political pressure to see filled. Fellow specialists have often been working frequent on call rosters. Both groups have vested interests in seeing that the newly recruited OTD can continue to work in their community. Working alongside colleagues usually engenders a degree of personal friendship. The pressures of work, and influence of friendship do not create an easy environment to provide objective assessment of a colleague's clinical skills. The people at risk from this potentially flawed assessment are the general public, and the OTD him/herself who may be given a false sense of confidence that their clinical performance meets community and regulatory authority standards. The system of oversight for practitioners considered substantially comparable could be made more robust but provision of a short period of orientation/assessment prior to commencement in their substantive post, and for there to be a requirement for the oversight process to include periodic review by a peer with whom the specialist is not working with from day to day.

4. The hardest assessments to make in assessing overseas trained specialists are of those who are considered partially comparable. The assumption is that those assessed in this group will be able to work at the level of a 'senior registrar' - a senior specialist trainee in the Australian system - who has most of the skills required to work as a specialist and can work with minimal supervision. In my experience this is rarely the case. In my time as Chairman of the RANZCOG OTD AON Committee many complaints were received from Hospital managers or senior clinicians when a partially comparable trainee had been employed only to find that they were incapable of working at the level of an Australian senior registrar.
   [redacted]

[redacted]

5. Area of Need 'specialist'' clinicians are often recruited in situations where there is minimal peer support and direct supervision. Such clinicians when assessed against Australian specialist standards more often than not meet the 'partially comparable' standard. This is an unjust situation from the perspective of rural communities who are nominally provided with a 'specialist' service, when in fact they are provided 'specialist' care by a practitioner who does not meet the requirements of specialist recognition. The process of matching a clinician's particular skills against a particular rural specialist role is flawed when that assessment – both of the position and of the clinician are based on paperwork and an interview. Such positions are at least nominally supervised: in reality this may be supervision primarily at a distance – which assumes the AON clinician has the required insight to know when to seek advice, or by periodic observation by a visiting specialist. The latter is better than nothing but does not guarantee appropriate clinical scrutiny. Again, the supervisor is under local and personal pressure to ensure that the AON clinician can continue to work in the position to which they have been recruited. The supervisor is not necessarily a disinterested party.
   AON positions were created to allow health services to fill gaps to which local graduates cannot be recruited. In reality they have created a level of second tier specialist services and which have allowed health services to avoid the issue of ensuring that the support, incentive and working conditions that should be provided to attract locally trained specialists. AON positions also create situations where OTDs can avoid pursuing the requirements and attaining the skill set and knowledge needed to meet permanent registration to work as a specialist in the Australian workforce.

   In my view the AON system for providing specialist services in rural areas is potentially fatally flawed and should be wound down and disbanded. With increasing availability of Australian trained specialists and OTDs who have obtained specialist recognition in Australia, rural health services should be looking to create employment opportunities and conditions which meet the expectations of specialists, locally or overseas trained, with full Australian specialist registration.

6. The sequential process of AMC assessment followed by Registration application can lead to unnecessary and expensive time spent with AMC assessment when registration investigations reveal outstanding disciplinary issues, and can lead to unnecessary delays in practitioners commencing work whilst the registration authority enquiries run their course for practitioners who are eligible for provisional registration.

So how can the system be improved to increase the likelyhood that OTDs working in the Australian health care setting meet community standards in an efficient and fair manner, with particular reference to obstetrics and gynaecology specialist registration?

1. AHPRA and AMC initial assessments should be concurrent to verify medical training qualifications and the absence of outstanding overseas disciplinary issues. If one or other process identifies a situation which would disqualify an applicant from working as a doctor in Australia, then the other agency can call a halt to their enquiry.
2. Assessment of all overseas trained specialists should include a period, albeit brief in some instances, of independent workbased assessment. Tertiary and large outer metropolitan and regional health care centres should be funded and resourced to establish OTS specialist assessment processes similar to that established by Rural Health West for assessment of OTD GP obstetricians. This would enable doctors considered suitable for assessment as specialists based on their CV and referee reports to demonstrate the specialist skills claimed. Such assessments must be in closely supervised, independent and busy clinical settings. The duration of the assessment period would have to be flexible : for some it would be very apparent within 2 weeks that a clinician did not have skills anywhere near that required of an Australian specialist. For such clinicians, further College assessment could be unneccesary. Such clinicians would then be directed to non specialist registration processes. Having been given the chance to work under supervision in a clinical setting in Australia, and been found wanting would hopefully make the acceptance of the 'not near to' assessment more likely when compared to a decision based on interview and paperwork alone.
   If Colleges each had a state based panel of accredited Overseas Trained Specialist assessors, then those who had been deemed suitable for interview could not only undergo workbased assessment, but also interviewed consistent with a national standard process at the same time. At the conclusion of two weeks, then an assessment could be given of not comparable, partially comparable or comparable to an Australian trained specialist. Videoconference facilities could be used to include participation of members of assessment panels from other states to add balance and independence to assessment interviews and decisions based on the combined information gained from document, interview and clinical skills assessment processes.

Inclusion of a clinical skills based assessment in the initial assessment process would improve the detection of major skill deficits in the not insignificant group of practitioners who are currently assessed as 'partially comparable' and who subsequently struggle to complete College requirements for Fellowship as the gap between their actual skill set is much greater in practice than indicated by their AMC assessment as it currently stands. This would reduce the number of OTDs pursuing examinations

they are likely to fail and the number of frustrated employers who find their apparently 'partially comparable' specialist registrar does not have the expected clinical skills. This situation is very stressful for all concerned and not easily remedied. Better that such doctors receive an accurate assessment in the first place and redirect their energies at achieving non specialist registration.

Attempts to 'short track' the process for OTDs seeking to work in the Australian health care sector should ensure that only those with appropriate training and skills are able to benefit from this drive. Those who do not have equivalent training and skills should have the opportunity to complete the required assessments and training in very well resourced, and objective major centres, not in poorly resourced health services. Where such services required assistance in maintaining service provision, this should be via working conditions that attract fully qualified doctors be they locally or overseas trained doctors. To free up training opportunities for overseas trained doctors in metropolitan centres, senior specialist and GP trainees should be rotated through rural centres in greater numbers than occurs at present, with pressure placed on College's to ease local supervision requirements for senior trainees to allow this to occur.

In short, I recommend more responsibility for assessment and training of OTDs in metropolitan centres to improve the quality of assessment and potential speed of upskilling of OTDs to meet Australian care standards, and more emphasis on attractive working conditions and local training programme arrangements to help support rural health services.

Diane Mohen
MBBS(UWA) BMedSci FRANZCOG
Consultant Obstetrician & Gynaecologist.
[redacted]